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NO. NO. 60554-2-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, a Washington nonprofit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2 d/b/a EVERGREEN HEALTH CARE, a Washington Public Hospital District,

Petitioner,

v.

STATE OF WASHINGTON DEPARTMENT of HEALTH,

Respondent,

PETITION FOR REVIEW

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I. IDENTITY OF PETITIONER

Petitioner is the Department of Health, State of Washington (Department).

II. COURT OF APPEALS DECISION

The Department seeks review of the decision of the Court of Appeals, Division I, in *Overlake Hospital Association v. Department of Health*, 146 Wn. App. 1074 (2008). Appendix (App.) at 1-8. The Court of Appeals denied a motion for reconsideration on December 29, 2009, and granted a motion to publish on December 30, 2009. Appendix at 9-10.

III. ISSUE PRESENTED

Under RCW 70.38, Swedish Health Services (Swedish) applied to the Department for a Certificate of Need to establish a new ambulatory surgery center (ASC) in Bellevue with five operating rooms that would be available for use by any physician with privileges. [1] The Department applied the methodology in WAC 246-310-270(9) to determine whether there was "need" in the planning area for the additional operating rooms

[1] An ASC is a facility where surgeries are performed without overnight hospitalization of the patient. WAC 246-310-010(5).

proposed by Swedish.[2] App. at 11-12. Operating rooms in offices of private physicians – and used only by those physicians – are exempt from Certificate of Need approval. The Department, in applying the language of the methodology, did not count these private exempt operating rooms as being available to meet the public demand for operating rooms. In other words, under the methodology, the Department determined there should be a sufficient number of *Certificate of Need-approved* operating rooms to meet the total public demand.

If this case is accepted, the issue will be:

Did the Court of Appeals err in holding that the Department was arbitrary and capricious in applying WAC 246-310-270(9) in a manner that assured a sufficient number of Certificate of Need-approved operating rooms in East King County to meet the total public demand?

IV. STATEMENT OF CASE

The Department adopts by reference the Statement of Case in Swedish's Petition for Review. Petition at 4-8.

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[2] The planning area for a proposed ASC is Bellevue in East King County. Overlake Hospital Association, which contests the Department's determination in this case, already has operating rooms in East King County.

V. ARGUMENT FOR WHY REVIEW SHOULD BE ACCEPTED

This Petition for Review should be accepted by the Supreme Court under RAP 13.4(b)(4) because the petition involves an issue of "substantial public interest" regarding public health care and the method for determining future community needs.

A. Certificate Of Need Cases Involve Substantial Public Interest

The Court of Appeals reversed the Department's decision to grant Swedish a Certificate of Need to establish an ambulatory surgery center in Bellevue. A Certificate of Need applicant must meet four criteria: need (WAC 246-310-210); financial feasibility (WAC 246-310-220); structure and process of care (WAC 246-310-230); and cost containment (WAC 246-310-240). Certificate of Need approval is required for a variety of health care facilities. RCW 70.38.025(6). The policy behind the Certificate of Need law is to:

> (P)romote, maintain, and assure the health of all citizens in the state, provide assessable health care services, health manpower, health facilities, and other resources, while controlling increases in costs...

RCW 70.38.015(1). At issue in a Certificate of Need case is access to health care services. This issue inherently is one of substantial public interest. In fact, few things are of greater interest to the public than access to health care.

B. Substantial Public Interest Exists In This Case Because It Impacts The Number of Ambulatory Surgery Center Operating Rooms That Will Be Available To Meet The Public Need

An ASC is a facility where surgeries are performed in operating rooms on patients not requiring hospitalization. Certificate of Need approval is required to establish an ASC, except when the operating rooms are located in the offices of private physicians for the exclusive use of those physicians. WAC 246-310-010(5). These are called "exempt facilities."

The WAC 246-310-270(9) methodology determines "need" for additional operating rooms in part by examining (1) the number of existing operating rooms in a planning area, and (2) the number of surgeries being performed in the planning area. As explained by the Court of Appeals, in performing the methodology to calculate need for new operating rooms in a planning area, the Department (1) does not count exempt facilities when determining the number of existing operating rooms, but (2) does count the exempt facility volume in determining the number of surgeries being performed in the planning area. App. at 3-4. The Department thereby assures a sufficient number of *Certificate of Need-approved* operating rooms to meet the total public demand, *without* having to rely on exempt facilities to meet part of that demand.

The Department bases its interpretation on the actual language of WAC 246-310-270(9) and the intent of the Certificate of Need law to assure health care is accessible to all members of the public. Swedish Petition For Review at 9-10. A Health Law Judge and the superior court upheld this interpretation.

However, the Court of Appeals held the Department's interpretation is arbitrary and capricious and "over-calculates" the need for additional operating rooms in a planning area. App. at 6. The Court of Appeals erred by failing to recognize that, given the Department's special knowledge and expertise, the Court must accord "substantial deference" to the agency's interpretation of the Certificate of Need law. *Univ. of Wash. v. Dep't of Health*, 164 Wn.2d 95, 102, 187 P.3d 243 (2008).

The fact is that public demand for outpatient surgery is growing because of population increases, technological advances, and patient preferences. Swedish Petition for Review at 4. The Department calculates that under the WAC 246-310-270(9) methodology, there will be a shortage of 12 operating rooms in East King County in 2009. *Id.* at 5. The Court of Appeals incorrectly concluded the Department's interpretation of the rule – not counting the private operating rooms as available – inevitably would result in a finding of need for additional operating rooms in a planning area. *Id.* at 10-11.

There is substantial public interest in a decision that overturns the Department's long-standing interpretation of WAC 246-310-170(9) and limits the number of new operating rooms that will be available to serve all members of the public in the future. This fact was acknowledged by Overlake itself in its successful motion to publish when it noted that the Court of Appeals' decision "has a significant impact on the public" because it impacts several pending ASC applications in East King County as well as all future applications in the state. Swedish Petition for Review at 15.

VI. CONCLUSION

Based on the foregoing, the Department of Health respectfully requests that the Supreme Court grant the Petition for Review.

RESPECTFULLY SUBMITTED this 29 day of January, 2009.

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APPENDIX

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, a Washington nonprofit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN HEALTHCARE, a Washington Public Hospital District, Appellants, v. DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, Respondent.	No. 60554-2-I DIVISION ONE UNPUBLISHED OPINION FILED: October 13, 2008

GROSSE, J. – Although a high level of deference is accorded to an agency's determination under the Administrative Procedure Act,[1] such deference will not lie where an agency's decision is based on an implausible interpretation of its regulations. Here, the Department of Health promulgated rules for determining whether a need exists for additional ambulatory surgical facilities in Bellevue that employ a flawed mathematical formula to establish the number of current and projected surgeries. That flawed formula included exempt surgical procedures in calculating demand, but excluded the facilities where exempt surgical procedures are performed from the calculation of existing capacity.

[1] RCW 34.05.570.

Hence, in an area where there is much private, exempt care, as Bellevue, the calculation will inevitably be biased toward need. Accordingly, we reverse the determination that Swedish Health Services could establish a five-bed ambulatory surgical facility on the eastside.

FACTS

The Washington Legislature enacted the State Health Planning and Resources Development Act in 1979, creating the certificate of need (CN) program to oversee health care development.[2] The CN program is an office within the Department of Health (Department) designed to effectuate the goals and principles of the Act. In order to establish or expand health care facilities, a provider must obtain a CN.[3] For that, a health care provider must establish a need for a particular health care service or facility in that health care planning area. CN applications are evaluated based on specific criteria set forth in the statute and applicable rules.[4]

To determine whether additional inpatient and outpatient operating rooms are needed in a health planning area, the Department uses the mathematical formula set forth in WAC 246-310-270(9). This formula is a means to compare current operating room capacity in a particular health planning area against anticipated future need, if any. Essentially, the methodology requires three steps:

- Existing Capacity: calculate the capacity of existing

[2] RCW 70.38.015(2).
[3] RCW 70.38.105; St. Joseph Hosp. v. Dep't of Health, 125 Wn.2d 733, 735, 887 P.2d 891 (1995).
[4] Chapter 70.38 RCW; WAC 246-310.

operating rooms in the planning area;

- Future Need: project the anticipated number of surgeries in the planning area three years into the future; and

- Net Need: calculate whether the existing operating room capacity is sufficient to accommodate the projected number of future surgeries. If not, then a need exists for more ambulatory surgical facilities in the planning area..

Here, the Department issued a CN to Swedish Health Services (Swedish) to establish an ambulatory surgical facility with five operating rooms in Bellevue. An ambulatory surgical facility is defined as "any free-standing entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization."[5]

Evergreen Healthcare and Overlake Hospital Medical Center (collectively, Overlake) filed an objection to the issuance of the CN to Swedish alleging that there was no need for additional ambulatory surgical facilities in the area. The health law judge rejected Overlake's appeal, upholding the methodology employed by the Department in granting Swedish the CN. Overlake appealed to the superior court which upheld the health law judge. Overlake appeals.

ANALYSIS

Certain surgical facilities are exempt under the CN scheme. Exempt facilities include those located in the offices of private physicians that are unavailable for outside use. [6] In determining current operating room capacity under the Existing Capacity step, the Department does not include exempt

[5] WAC 246-310-010(5).
[6] WAC 246-310-010(5).

facilities where surgeries are currently performed. However, when computing whether additional operating rooms are needed under Future Need, the Department does include surgeries performed at exempt ambulatory surgical facilities. In short, the formula either undercounts the number of surgeries in the first step or over-counts the number of surgeries to be performed in the second step.

Overlake objects to the inclusion of surgeries at exempt facilities when the Department excludes those facilities to determine capacity. Both Existing Capacity and Future Need in the methodology use the terms "operating rooms" and "surgeries." As noted by the health law judge, the plain language of the governing WAC rule does not differentiate surgeries in exempt facilities from surgeries in nonexempt facilities. Nonetheless, the health law judge acquiesced in the Department's interpretation, permitting it to include surgeries performed at exempt facilities when calculating projected surgeries, but exclude those very same facilities when calculating the number of operating rooms needed to meet the demand for projected surgeries. Such an application makes no logical sense and is contrary to the basic canons of statutory interpretation. Indeed, we can envision no scenario where the Department's application of the formula will not result in a showing of need (except where there are no exempt facilities).

Testimony at the administrative hearing indicated that the Department's rationale for this unsound practice lay in the Legislature's policy directive to provide "accessible" health care. But, access to health care, though important,

was only one reason motivating the Legislature in creating the CN program. The Legislature's primary purpose was to control costs by limiting competition.[7] The Legislature clearly enunciated its goals in its declaration of public policy:

> That strategic health planning efforts must be supported by appropriately tailored regulatory activities that can effectuate the goals and principles of the statewide health resources strategy developed pursuant to chapter 43.370 RCW. The implementation of the strategy can promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities, and other resources while controlling increases in costs, and recognize prevention as a high priority in health programs.[8]

As the Supreme Court in Saint Joseph Hospital v. Department of Health noted:

> While the Legislature clearly wanted to control health care costs to the public, equally clear is its intention to accomplish that control by limiting competition within the health care industry. The United States Congress and our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down and government therefore needed to restrain marketplace forces. The means and end here are inextricably tied.[9]

The formula as interpreted and applied here by the Department is not particularly helpful in achieving any of these goals as it results in a formula that is fundamentally unsound. Sound reasoning requires the concomitant inclusion or exclusion of exempt facilities. To do otherwise defies logic and the plain meaning of the language used throughout the pertinent WAC.

On remand, the Department may very well come to the same conclusion it reached. Indeed, there is nothing that would prevent the Department from

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[7] RCW 70.38.015(1).
[8] RCW 70.38.015 (1) (emphasis added).
[9] 125 Wn.2d 733, 741, 887 P.2d 891 (1995).

discounting private surgical procedures and facilities entirely should it so choose. But here, the Department's decision to issue Swedish the CN was arbitrary and capricious because it was based on an erroneous interpretation of the governing statutes and a misapplication of its own regulations. The Department's calculation necessarily resulted in an over-calculation of future need for additional outpatient operating rooms in the East King County Planning Area. Because we find that the Department misapplied its own rule (WAC 246-310-270 (9)),[10] we reverse.

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[10] The WAC provides in pertinent part:

> (9) Operating room need in a planning area shall be determined using the following method:
>
> (a) Existing capacity.
>
> (i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.
>
> (ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.
>
> (iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.
>
> (iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour

Grosse, J

WE CONCUR:

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dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

Ellington, J. Becker, J.

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, a Washington nonprofit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN HEALTHCARE, a Washington Public Hospital District, Appellants, v. DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, Respondent.	No. 60554-2-I ORDER DENYING MOTION FOR RECONSIDERATION

The respondents, Department of Health of the State of Washington and Swedish Health Services, have filed a motion for reconsideration herein. The appellants have filed an answer to the motion. The court has taken the matter under consideration and has determined that the motion for reconsideration should be denied.

Now, therefore, it is hereby

ORDERED that the motion for reconsideration is denied.

Done this 29th day of December, 2008.

FOR THE COURT:

Grosse, J

Judge

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, a Washington nonprofit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN HEALTHCARE, a Washington Public Hospital District, Appellants, v. DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, Respondent.	No. 60554-2-I ORDER GRANTING MOTION TO PUBLISH

The appellants have filed a motion to publish herein. The respondent, Swedish Health Services, have filed an answer to the motion. The court has taken the matter under consideration and has determined that the motion to publish should be granted.

Now, therefore, it is hereby

ORDERED that the motion to publish the opinion filed in the above-entitled matter on October 13, 2008 is granted. The opinion shall be published and printed in the Washington Appellate Reports.

Done this 30th day of December, 2008.

FOR THE COURT:

Grosse, J

Judge

WAC 246-310-270 No agency filings affecting this section since 2003

Ambulatory surgery.

(1) To receive approval, an ambulatory surgical facility must meet the following standards in addition to applicable review criteria in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240.

(2) The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.

(3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, Central King, Southwest King, Southeast King, Central Pierce, West Pierce, East Pierce, Mason, West Grays Harbor, Southeast Grays Harbor, Thurston, North Pacific, South Pacific, West Lewis, East Lewis, Cowlitz-Wahkiakum-Skamania, Clark, West Klickitat, East Klickitat, Okanogan, Chelan-Douglas, Grant, Kittitas, Yakima, Benton-Franklin, Ferry, North Stevens, North Pend Oreille, South Stevens, South Pend Oreille, Southwest Lincoln, Central Lincoln, Spokane, Southwest Adams, Central Adams, Central Whitman, East Whitman, Walla Walla, Columbia, Garfield, and Asotin.

(4) Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.

(5) When a need exists in planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.

(6) An ambulatory surgical facility shall have a minimum of two operating rooms.

(7) Ambulatory surgical facilities shall document and provide assurances of implementation of policies to provide access to individuals unable to pay consistent with charity care levels provided by hospitals affected by the proposed ambulatory surgical facility. The amount of an ambulatory surgical facility's annual revenue utilized to finance charity care shall be at least equal to or greater than the average percentage of total patient revenue, other than medicare or medicaid, that affected hospitals in the planning area utilized to provide charity care in the last available reporting year.

(8) The need for operating rooms will be determined using the method identified in subsection (9) of this section.

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year

of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

[Statutory Authority: RCW 70.38.135 and 70.38.919. 92-02-018 (Order 224), § 246-310-270, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-310-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 70.38.919. 90-16-058 (Order 073), § 248-19-700, filed 7/27/90, effective 8/27/90.]